DESIGNATION OF PERSONAL REPRESENTATIVE

For the Use and Disclosure of Protected Health Information

Mail To: Privacy Officer, Colorado Department of Health Care Policy and Financing
1570 Grant Street, Denver, CO 80203

Please include copy of client's Medicaid ID card, Driver's License or equivalents for both the client and Designated Personal Representative, and any available documentation providing legal authority

The Health Insurance Portability and Accountability Act of 1996 states that you have the right to have one or more persons act as your representative to make decisions about the uses and sharing of your protected health information. You can limit the amount of protected health information that the authorized personal representative(s) can decide about, and you can cancel this at any time. See the Department's Privacy Policy and Procedures on *Personal Representatives,* pursuant to 45 C.F.R. 164.502(g).

Date: _____

DESIGNATION OF PERSONAL REPRESENTATIVE

I, _____ (print your name) hereby name the following person to act as my authorized personal representative with respect to decisions involving the use and/or sharing of protected health information that pertains to me.

_____ _____
Name of Personal Representative Relationship to Client

_____ _____
Personal Representative Social Security # Personal Representative Phone

LIMITS TO THE AMOUNT OF INFORMATION PROVIDED – Please check one

_____ The person named above is to be given all of the privileges that would be given to me with respect to my protected health information.

_____ The person named above is acting as my designated personal representative ONLY for the following function(s):

_____

_____

State ID number: _____ Client signature: _____

Date of birth: _____ Social Security # : _____

REVOCATION SECTION

I understand that I may cancel this designation at any time by signing the revocation section below and returning it to the Department's Privacy Officer at the above address. I understand that any revocation can only apply to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect.

I no longer want this person to act as my personal representative

Signature: _____ Date: _____